Medical Statement for Meal Modifications in Child and Adult Care Food Program (CACFP) Adult Day Care Centers

This form applies to requests for meal modifications for adult participants in adult day care centers participating in the U.S. Department of Agriculture's (USDA) CACFP. CACFP adult day care centers are required to make reasonable meal modifications for participants whose physical or mental impairment restricts their diet. For guidance on meal modifications and instructions for completing this form, see the Connecticut State Department of Education's (CSDE) document, *Guidance and Instructions for the Medical Statement for Meal Modifications in CACFP Adult Day Care Centers*.

Note: The USDA requires that the medical statement includes: 1) information about the participant's physical or mental impairment that is sufficient to allow the adult day care center to understand how the impairment restricts the participant's diet; 2) an explanation of what must be done to accommodate the participant's disability; and 3) if appropriate, the food or foods to be omitted and recommended alternatives. **CACFP adult day care centers should not deny or delay a requested meal modification because the medical statement does not provide sufficient information.** When necessary, the adult day care center should work with the participant or responsible family member to obtain the required information. While obtaining additional information, the CACFP adult day care center should follow the portion of the medical statement that is clear and unambiguous to the greatest extent possible.

Section A – Completed by participant or responsible family member

1. Name of participant: _____ 2. Birth date: _____
3. Name of responsible family member (if applicable): _____
4. Phone number (with area code): _____ 5. E-mail address: _____
6. Address: _____ City: _____ State: _____ Zip: _____

7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____
name of participant's recognized medical authority
to release such protected health information as is necessary for the specific purpose of special diet information to _____ and I consent to allow the recognized medical authority to freely
name of CACFP adult day care center
freely exchange the information listed on this form and in my records with the adult day care program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet. I understand that I may rescind permission to release this information at any time except when the information has already been released.

8. Signature of participant or responsible family member: _____ 9. Date: _____

Section B – Completed by participant's recognized medical authority

This section must be completed by the participant's physician, physician assistant, doctor of osteopathy, or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

10. **Physical or mental impairment:** Does the participant have a physical or mental impairment that restricts the participant's diet?
☐ **No** ☐ **Yes:** Describe how the participant's physical or mental impairment restricts the participant's diet.

11. **Diet plan:** Explain the meal modification for the participant. Attach a specific diet plan, if needed.

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Section B – Completed by participant's recognized medical authority, continued

12. **Food omissions and substitutions:** List foods to be omitted from the participant's diet and foods to be substituted**.**

13. **Food texture:** List foods that require a change in texture. Indicate "all" if all foods should be prepared in this manner.
    - ☐ Cut up or chopped into bite-size pieces: _____
    - ☐ Finely ground: _____
    - ☐ Pureed: _____

14. **Equipment:** List any special equipment or utensils needed.

15. **Additional information:** Indicate any other information about the participant's eating or feeding patterns that will assist in providing the requested meal modification.

16. Name of recognized medical authority: _____ 17. Phone number (with area code): _____

18. Signature of recognized medical authority: _____ 19. Date: _____

20. Office stamp:

This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/SpecDiet/Adult_Medical_Statement_CACFP.pdf